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PAPER

Emerging themes in the everyday ethics of primary care: a report from an interdisciplinary workshop

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Abstract

We report key themes arising from a postgraduate workshop organized by the King's Interdisciplinary Discussion Society (KIDS) held in April 2011. KIDS believe that health is a phenomenon that transcends disciplinary boundaries, and therefore issues relating to health care and medical ethics are best addressed with an interdisciplinary approach. The workshop, entitled 'Everyday Ethics and Primary Healthcare', included poster presentations and oral presentations from participants from a range of disciplines and occupational backgrounds which highlighted the challenges faced by primary health-care workers. Three common themes emerged: the impersonal and cumbersome work environment that can result from the encroachment of rationalizing tools; the tension between 'ethical practice as an ongoing sensibility' and 'ethical practice as "box-ticking"'; and the contested nature of what constitutes 'health'. Participants felt that the interdisciplinary perspective was helpful in elucidating the various ethical issues arising in primary health care.

On KIDS

The King's College London Interdisciplinary Discussion Society (KIDS) is a working group with a specific focus on issues relating to health care and medical practice. KIDS was founded on the premise that health is a phenomenon that transcends disciplinary boundaries, and that many contemporary issues related to health care, health policy and medical ethics are therefore best addressed with an interdisciplinary approach. Accordingly, KIDS is composed of postgraduate students and postdoctoral fellows from a range of academic backgrounds including medicine, law, sociology and philosophy, and we have held workshops and seminars on key health-related issues bringing together medical practitioners and health professionals, academics, students, and members of the public. In this paper we discuss themes arising from a KIDS workshop which focused on the topic of clinical ethics in the context of primary care.

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John Owens currently holds the position of Blackwell Post-Doctoral Research Associate at the Centre for Public Policy Research, King's College London. John has a background in applied philosophy and his research explores the implications of epistemology and ontology on health-care policy and bioethics.

Hilary Engward is a Senior Lecturer at Anglia Ruskin University where she leads an MSc in Medical and Health Care Education. Hilary's research interests are in knowledge mediation of ethics in health professional education, the application of ethical concepts in the health and social care context and the theoretical and methodological foundations of empirical ethics research.

Introduction – the need for an exploration of primary care ethics

The 'Everyday Ethics and Primary Healthcare' workshop was held in early April 2011. The aim of the workshop was to explore some of the key ethical challenges involved in contemporary primary health care and to facilitate discussion on how such challenges might be overcome. In selecting our topic for discussion we noted calls to establish a 'definitive place' for primary care ethics 'on the "bioethics map"'.[1,2] However, aware of the contested nature of 'primary care' and thus 'primary care ethics',[3] as well as the tendency for much of the debate on the subject to focus on the challenges facing general practitioners,[1,4] we decided to employ a definition of primary care which included the work of all community-based health professionals.

Much of the discussion in the field of bioethics typically focuses on the more extraordinary dilemmas arising in high-technology medicine and tertiary care, and the ethics of primary care is largely overlooked.[4] Yet, important ethical issues are ubiquitous in primary care, and given the vast number of primary care consultations that

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take place daily, the effects of not adequately examining such issues could be profound.[2] Primary care (particularly general practice) is also a distinct area of academic and professional interest with unique ethical challenges that cannot necessarily be subsumed into more general bioethical discussions. In addition to treating symptoms and preventing problems within a biomedical framework, primary care health workers help patients make sense of their illness, and in the case of intractable illnesses, assist in planning their lives or helping them prepare for death.[5] Primary health-care workers are not simply biomedical technicians; they are often required to manage emotional and potentially delicate interactions. Because of this complexity, we believe that an interdisciplinary perspective can provide valuable insights into the everyday ethics of primary health care. Workshop participants were invited to present posters, and three key speakers were invited to present: Hilary Engward of Anglia Ruskin University, once a practising nurse and now a PhD candidate exploring medical training and the teaching of medical ethics; Peter Toon of Queen Mary University of London, a general practitioner (GP) with an interest in the philosophy of medical practice; and John Owens of King's College London who has recently completed an applied philosophy PhD in the area of health care and public policy. By inviting three speakers from different backgrounds but with a common interest in health care and ethics, we sought to stimulate lively and productive interdisciplinary discussion.

Presentations – challenges in primary health care

The workshop began with a viewing of poster presentations. Using theoretical insights from science and technology studies, Richard Boulton presented an argument which suggested the problems of dealing in absolute ethical principles in the context of health-care practice: ethics is situated and performative, and what counts as 'ethical practice' will inevitably vary according to context.[6] Two medical students from King's College London used the concept of 'power' to discuss the challenges associated with consultations where the patient is also medically qualified.[7] A junior doctor, using a fictionalized case-study of a child repeatedly missing appointments, explored some of the issues with child-safeguarding in British general practice.[8] There was also a poster showcasing a previous gathering of academics, educators and practitioners, which sought to cultivate a distinct body of knowledge and community of scholars relating to the ethics of primary health care.[9] All posters highlighted the difficulty of working within an environment characterized by uncertainty.

Hilary Engward presented findings from her PhD research on the teaching of medical ethics. Engward noted that what counts as being an 'ethical issue' according to an ethicist is certainly not always apparent to those immersed in clinical practice. It is during medical training that many health-care workers learn to identify what constitutes an 'ethical issue' and are taught various skills for dealing with such issues. Engward argued that at an undergraduate level, this teaching of health-care ethics is dominated by an ethics of principlism, which does not always transfer easily into actual health-care practice.

Peter Toon explored a 'Flourishing practice' using Alasdair Macintyre's virtue ethic framework to elucidate Q1 the challenges encountered by contemporary general practitioners. He took the term 'practice' to mean the thing that a particular group or profession 'does' in this context. Macintyre argues that the modern world can be characterized by a moral fragmentation; the modern world lacks any overarching, moral coherence. Toon suggested that in general practice, this moral fragmentation manifests in the imposition of various 'isms', each representing different values: consequentalism, legalism, manageralism, 'rights' and 'duties', and consumerism. While each of these perspectives represent an attempt to provide clear, ethical direction for clinicians and patients, Toon argued that they can impede good health care by imposing onerous, irrelevant, impersonal and sometimes conflicting protocols. For example, primary health care has been influenced by the strong culture of consequentialism that is prevalent within public health ethics and the shift towards preventative medicine However, the use of cost–benefit analysis techniques (such as quality-adjusted life years, QALYs) can be impractical and may disadvantage the disabled and most vulnerable by being insensitive to the personal, cultural and medical differences between patients.

Legalism, Toon argued, has brought about an over-reliance on evidence and documentation, and prompts clinicians to engage in defensive medicine. Similarly, an increasing emphasis on 'achieving targets', league tables and quality and outcomes framework documentation have created a climate of manageralism, where practising 'good medicine' is a matter of following correct procedure and 'ticking the boxes'. The rephrasing of general practitioners as 'health-care providers' and patients as 'consumers' signals a shift towards a more market-based approach to medicine. This implies that health care can be treated as a product, an end in-itself, and that patients should be afforded the right to pick and choose among health-care providers. Toon argued that the influence of greater marketization may be problematic for primary care practice: not only does it fail to produce clear and coherent ethical guidelines but also contributes to a less-meaningful and less-rewarding work environment for primary health workers.

John Owens examined 'Commissioning, choice and personalized health care', exploring the movement towards a more market-based form of health-care provision. Owens, drawing on his philosophical training, presented a critical overview of recent proposals to introduce a general practice-led commissioning structure with the wider policy aim of creating a 'patient-led NHS'. The switch to GP-led commissioning is promoted as a means of 'empowering' patients by fostering patient autonomy: health-care services will become more responsive to

patient needs, and patients will have greater choice in selecting services. Yet, as Owens pointed out, this is problematic for several reasons. Firstly, a personalized, patient-led NHS may need to accommodate a plurality of beliefs and values, some of which may conflict with the judgement of practitioners. The rhetoric of 'choice' and 'autonomy' may also compromise the wellbeing of patients should they be left to decide upon the nature of the treatment they receive, as well as the means of its delivery. Secondly, referring to the 'inverse care law',[10–12] Owens stated that it is often those in greatest need who fail to seek health care, meaning that the introduction of greater choice may serve to widen health inequalities by serving the interests of those who actively seek care and doing little for those who do not. Owens argued that if health inequalities are to be reduced and reforms are to genuinely empower patients, it is necessary to go beyond the popular rhetoric of autonomy as choice and seek a broader definition of the term.

Discussion – key themes and moving forward

Three key themes emerged from the poster and oral presentations and the subsequent discussion. Firstly, presentations highlighted the increasing encroachment of external influences in primary health-care practice. For instance, in the past general practice was considered a specialist domain of activity best left to the skilled physician. In this more traditional era, the training and tacit knowledge of the physician was considered sufficient to guide decision-making. However, in an effort to curtail the rising costs of medicine and move towards a less paternalistic model, general practice has become increasingly subjected to rationalizing tools and protocols while simultaneously subjected to a political rhetoric emphasizing patient choice. These tools and protocols can be seen to create a cumbersome and impersonal work environment. Additionally, they can have an adverse effect on the doctor–patient relationship, hindering the physician's ability to flexibly negotiate complex clinical interactions which, due to the diverse nature of patients and uncertainties associated with illness, are never identical. There seems to be a significant risk of conflict, then, between the inherently variable and sometimes unpredictable nature of medical practice, and the various attempts to rationalize, manage or commercialize health-care provision.

The second emerging theme, the tension between 'ethical practice as an ongoing sensibility' and 'ethical practice as "box-ticking"', relates to this conflict. Toon argued that a Macintyrean-based virtue ethics could provide practitioners with a means of navigating this conflict. Good, ethical practice emerges from the fostering of meaningful relationships and treating health care as means to an end, and not an end in itself. Both health-care workers and patients are the agents of good, ethical practice. This, Toon suggests, is preferable to a system where good, ethical practice is equated with following prescribed frameworks and guidelines. The teaching of a medical ethics-based principlism implies the latter, providing yet another set of standards for health-care workers to follow. As Engward illustrated, undergraduate nurses can find such ethical guidelines inadequate in the messy and complex practice of medicine. It was generally agreed among presenters that any attempt to produce useful and pertinent guidelines for good, ethical practice would require a greater knowledge of the everyday complexities of primary health care.

The third theme that emerged from the workshop was the contested nature of 'health'. Moves towards a more market-based provision of health, such as the commissioning initiative outlined by Owens, assume that health can be treated like a commodity. Yet, as both Toon and Owens indicated, what constitutes 'health' can vary: for some, it is more than simply being free of disease, and for others, a sense of health can still be achieved in the midst of chronic illness. It is perhaps more appropriate that health be treated as an ongoing project that will differ for each patient. During group discussion, Owens referred to Annemarie Mol's *The Logic of Care* 2008,[13] which argues that the market-based logic of choice will undermine the ability of medical practitioners to provide good care. Good care results from the collaborative and continuous effort of both the practitioner and the patient. In this rendition, health is not a product, but a collaborative practice of 'living life well'. Accordingly, best practice for primary care will suffer from the encroachment of marketization and consumerism and the institutional culture of box-ticking which characterizes the doctor–patient relationship as one of provider and user.

It was agreed by all participants that the interdisciplinary perspective was particularly helpful in elucidating the various difficulties associated with the practice of primary health care. It was also agreed that these themes, and indeed ethics in primary care in general, require further exploration, something we hope to do in future KIDS events. Peter Toon, along with others involved in the study of primary care ethics, will be presenting ideas at the Royal College of General Pracitioners' conference this year. A further conference looking at the ethics of primary health care is planned for February 2012 at the Royal Society of Medicine. At the time of writing the next KIDS workshop is due to be held in November and will examine the topic of 'Enhancement, identity and the construction of categories in sport'.

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